Ohio Department of Job and Family Services

PERMISSION TO ADMINISTER MEDICATION FOR TYPE B FAMILY CHILD CARE AND IN-HOME AIDES

IMPORTANT: Complete a separate form for **each** child and **each** medication.

Directions: *Please take the time to read and understand all directions. All areas must be completed accurately to assure that the proper child receives the proper medication at the proper time via the proper route.*

Step One-Determine if medication is:

- ☐ "Over the counter" (OTC)-complete Box 1
- ☐ Prescription w/label attached- complete Box 1
- ☐ Sample Meds- complete Box 1 and 2
- ☐ OTC as prescribed by a health caregiver complete Box 1 and 2
- ☐ Food Supplement or Modified Diet-complete Box 1 and 2
- ☐ Topical product or lotion used as a preventative, up to one year- complete Box 1
- ☐ Topical product or lotion used for treatment of a condition -complete Box 1, (valid for 14 days)

Step Two- Hand medication (in the original container w/original label) to the provider assuring that the child's name is clearly indicated on the medication container.

Step Three- Provider/In-home aide reads the JFS 01644 and assures the caretaker has completed all required information and the provider understands the information. Assures caretaker has administered first dose of medication to child.

Step Four- Provider/In-home aide places medication in a safe location out of the reach of children. Does medication require refrigeration? ☐ Yes ☐ No

Step Five- Provider/In-home aide administers medication at proper time and records it on this form.

Step Six- Medication is sent home with the caretaker when no longer being administered or when it is expired.

☐ **Box 1**: Caretaker/Parent Request for Administration of Medication. *Complete for **all** products to be administered or applied to the child.*

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage (may **not** be "as needed")	Route (Ex: by mouth, in the eye, in the ear, etc)

To be administered at the following times	To be administered for the following period of time	Expiration date of medication

Is this medication a result of a special need or medical/health condition which may require the provider to have a Medical/Health Care Plan on file? ☐ Yes ☐ No

I give permission to the provider to administer the above medication to my child. I assure that my child has received the first dose of this medication and has not had any unexpected reactions. This permission is valid for no more than twelve months from the date of signature.

Caretaker/Parent Signature	Date of Signature

☐ **Box 2**: To be completed by the child's physician, dentist, physician's assistant or certified nurse practitioner for sample medications, OTC medication administered not in accordance with label instructions, for nonprescription medications that contain codeine or aspirin or for modified diets (when the entire food group is eliminated) or for food supplements.

Name of Child	Medication/Supplement/Vitamin

Dosage	Expiration Date (May not exceed 12 months)

Instructions

This child is under my care and should receive the above medication as written.

Healthcare Provider's Signature	Date	Telephone Number

Address	City	

Medication Log (Record all medications/products when administered)			
Date	Amount	Time	Provider's Signature

This is a prescribed form which must be used to meet the requirement of Chapter 5101:2-14 of the Administrative Code